COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

09-25-2015

Meeting Summary

Commissioners Present: Bill Lindsay (chair), Cindy Sovine-Miller (vice-chair), Elisabeth Arenales, John Bartholamew, Jeff Cain, Steve Erkenbrack, Linda Gorman, Julie Krow, Christopher Tholen, Liz Whitley (for Lary Wolk), Marcy Morrison, Ira Gorman

Staff: Lorez Meinhold and Cally King (Keystone)

I) Approval of the Minutes

A) Cindy Sovine Miller made a motion to approve the meeting minutes from September 14th, seconded by Jeff Cain.

B) There were no revisions or opposition to adopting the minutes.

II) Planning Committee Memo – Bill Lindsay/ Commissions

A) The Commission has received additional funding from Colorado Health Foundation.

B) Commission discussion:

1) When the memo mentions National Conference of State Legislators (NCSL) assisting with research on what is happening in other states, I'm concerned many of the things haven't actually happened in other countries and systems. Is there a way to enlarge the scope of what they're looking at? Also, NCSL is not always known for being a middle-of-the–road group, may want to look at other groups for balance like ALEC.

2) We've had conversations about regional stakeholders; when would these meetings kick in? The additional funding doesn't give opportunity to expand meetings or work groups of the Commission. The Planning Committee has been looking at a series of funding options going forward. The focus of the staff right now is on the November report, once that is behind us we'll move into fundraising activities. However, the other thing the Committee has talked about is when we might go back to the JBC for supplemental funding in the current budget. We will also look at private sources and some other avenues we haven't approached yet. If the Commission is able to secure additional funding, we hope it would be to do additional stakeholder and ad hoc work groups or maybe even a second round of statewide meetings.

III) Process for recommendations and parking lot items

A) At the last Commission meeting we found the process around recommendations quickly evolve into wordsmithing. The Planning Committee decided we should try to only capture key points during the Commission meeting that staff can then revise into prose for the Commission to review and approve.

1) The issue became that when we had an initial draft recommendations, Commissioners were calling staff and saying they didn't include something or things were missing; and we don't want individual Commissioners to start driving the bus behind the scenes.

2) The idea is that today we will have the discussion, solidify conceptual recommendations, staff then puts those into prose, and Commissioners can then take any concerns or revisions back to the Planning Committee to make a decision on whether or not to include, then take back to the full Commission at the next meeting.

B) Suggested Process:
    1) Initial meeting to present data on the topic area; potential recommendations can be made at this point
    2) Second meeting focused on recommendations that are captured by staff and then put into prose; attempt to agree on recommendations by consensus, if not, move to a vote.
    3) The recommendations will be kept on paper for continual review and for Commissioners to revisit, as needed.

C) Commission discussion:
    1) It would be useful to have a clear picture of what we've recommended after we leave the meeting. I'm not recommending we go back to wordsmithing, but think we should project the recommendation on the screen so we know what's in or what's out before we leave the room. We don't know when we leave whether or not there was agreement with the list.
    2) Sometimes there's a notion that a recommendation or idea sounds good but is lacking data and there is uncertainty of what it means in the bigger picture – those are items for the "parking lot". We can also take these items to funders for areas where we would like to spend more time if we had more funding to look at the issue.
    3) Commissioners should remember we are not obligated to put forth recommendations that are going to be blockbusters. The focus of this exercise capturing recommendations and parking lot items is longer term and for the final report of the Commission (not the interim report due this November).
    4) At the last Commission meeting we discussed the model of how the process works. At the end of the day we need to understand where people are and it's important to give input. I would like the ability to email after the conversation and have the ability to provide input if it was not captured correctly.
    5) When members are gone, do they have the opportunity to come back and talk about potential recommendations?
        (a) If someone is absent, there is an opportunity between meetings to provide input that would be put forward to the Planning Committee and then brought to the Commission.
    6) If there is contrary data to some of the statements, I would like a clear process to point those out. It seems the first report of the Commission should outline the contrary viewpoints very carefully so we're not just providing a one-sided view to things. Some of the language does seem very one-sided with a clear goal in mind where there is contrary evidence and differences of opinion.
        (a) There will be opportunity for that discussion during today's meeting. At the end of the day, we won't always have everyone agree on every point so we will need to deal with consensus. There is the opportunity to provide those differences. The recommendations we're working on won't be included in the November report, so it might be premature to include those differences in the report.
        (b) Still concerned with the granularity in the recommendations document.
    7) Do Commissioners have unlimited chances to disagree or is a recommendation put to bed once it's put to bed?
        (a) We can't continually revisit these recommendations but if there is a strong contradicting viewpoint, we need to decide on how to reflect that within the final report. There is also opportunity for a dissenting report as part of the overall report.
        (b) At what point is it put to bed? Is it end of the second meeting or another point?
            (i) Challenge is we'll never have everyone at every meeting. How would the rest of Commissioners want to handle?

- There are exceptional circumstances, but we should have Commissioners look and send in comments which would have to happen by the third topic area meeting finalizing the recommendations.
- I wouldn't worry about a formal process until a problem occurs.

8) This is going to be an iterative process with different topic areas that build upon each other as we move along, so we may have to reconsider some things as we learn more.
   (a) That is not out of the question.

IV) Transparency and Workforce topic area Language/Recommendations – Commissioners

A) **Transparency Language/Recommendations:**

1) When the Research Committee discussed this topic area there was a section on cash payments that is not mentioned in this list. Who controls where the cash flows?
   (a) We haven't had a conversation on cash payments with the full Commission
   (b) If the patient has a high deductible plan, transparency on cost changes their decisions.
      (i) If looking at from a value neutral perspective, then I would agree but if we start attaching values to it, then I would have to object.
2) The document says "research shows …" but doesn't include a reference or citation to the research; we need to see what is underlying the claims in the recommendations.
   (a) We can figure how to do that, perhaps with footnotes.
3) When we look at literature, one challenge is looking through the lens of a traditional insurance provider and need to make that clear in the documentation.
4) Transparency may have different effects on different groups. There's no negative effect on people without as much skin in the game, but there's probably value and efficiencies in other ways. Consumers will use information differently depending on how much cash they have on the line.
   (a) We can strengthen the case by pulling out the benefits by population/demographics.
5) To assume transparency is a universal good, we need to understand what that means and be thoughtful of the costs associated with transparency.
6) From a payer perspective, transparency to me is a document where I could look at similar provider groups and see how they render services, normalizing for client acuity and differences in population. This is a level of transparency I don't hear the Commission talking about. There's some transparency from the public sector side if we had documents to show comparisons across providers within a provider group. This information would be beneficial to more than just consumers.
   (a) I would also echo these comments from a private payer perspective.
   (b) Are these similar to provider registries?
      (i) It would be something a little more modern that tracks the types of things we want to look at that is normalized and within a provider group. Needs to have common standards.
   (c) Why haven't payers already done this?
      (i) It's typically due to a resource constraint.
      (ii) There is also the issue that not all providers embrace this concept with open arms. This is something along the lines we are doing with Medicaid pilot program in western Colorado. A given procedure can vary on a patient-by-patient basis.
      (iii) Were the narrowing of networks payers way of addressing the cost differential
   (d) If you compare across systems, need a single quality metric for common performance metrics

7) It seems there is a lot in the material on this topic area – standardization of data for submissions, clean claims, myriad sources from different payers in terms of metrics to comply with – this seems like a rich topic of conversation but one we would want to evolve.
8) There are three new Recommendations to be added:
    (a) If a patient controls where money goes, or has significant financial responsibility, transparency matters more and effects decision making.
    (b) Understanding issues around balanced billing
    (c) Transparency is beneficial not just to consumers and providers, but to payers and how they render services.
9) Transparency typically means money – but this has switched to looking at common quality metrics. The quality metrics may not even be something people want to value.
    (a) If we do need a separate conversation on quality, when does that happen?
        (i) I think we identify "quality" in the parking lot as a topic to be considered at some point. This is a very robust area to discuss.
    (b) Value includes cost and quality and people need both to make decisions. If we don't address value then we are doing a disservice to the topic area. As a provider, I've never been asked about quality or outcomes but constantly get asked about price.
    (c) Medicare advantage puts a five star rating on all their clients; it might not be perfect, but it can be done and provides a way to couple quality and value.
10) Parking lot suggestion that the state should not prevent the disclosure of provider taxes on bills – it should legal to do so.
11) Parking lot should also include consistent metrics for data gathering – ability to compare things on an apples to apples basis and how to standardize.

B) **Workforce Language/Recommendations**:
1) The background talks about scope of practice but it is not included in the recommendations. There should be a recommendation that we support individuals practicing at the height of their scope/license.
2) The background needs to include that it seems Colorado has made strides in this topic area, but there is more we can do.
3) Is there data on how many specialists Colorado has compared to other states?
    (a) When you have a lot of specialist training in one area, they tend to stay in those areas (i.e. Anschutz medical campus)
4) Where is the pathway for foreign trained physicians to obtain licensure in the United States? Would like a recommendation for the state to look at restrictions and if it is reasonable to be so restrictive.
    (a) Important to understand what accreditation means so people understand what they are getting from their physicians.
    (b) The problem is they can take the national exams, but can't get placed into the residency programs if they have been out of academia for more than 5 years.
        (i) Issue is we actually need more slots for residency programs, there's a high demand for a limited number of slots.
5) The recommendation to increase funding for Colorado Health Service Corps is one way to do it, but there are other ways that we should also list.
6) Medicaid payment for primary care should be on the list; one recommendation is that we adequately fund providers in primary care.
    (a) We have a separate topic area coming up on reimbursements.
7) We spent a lot of time talking about benefits of having a large primary care workforce, I thought we made recommendations on this topic that are not included - Recommendation on the value

of having a substantial primary care workforce and that the primary care workforce should be larger than the specialist workforce.

8) Workforce policy body should be explored to see how much is going on in Colorado, there are a number of efforts underway that fulfill that role and I would like to hear more about it.
9) If we say "value based payment" – we need to explain what that is.
10) "Continue Medicaid primary care model" in the parking lot – it is my understanding that we included this because of the general conversation around maintaining a primary care workforce. It seems the more general statement is that we need to not take policy steps that are contradictory. For this specific recommendation, I'm not sure if we have the underlying data to make the recommendation. We should support the maintenance and development of the primary care workforce in Colorado.
11) Reimbursement should be reflected in the needs of primary care providers.
12) I would like to see primary care defined, it may be that someone is better off getting primary care from a specialist. The state has been telling us for years there is no problem accessing Medicaid primary care, but there still seem to be access issues that can't be explained.
    (a) The Commission talked about definitions at the last meeting and decided when we talk about providers we mean someone who provides services (not necessarily a physician).
13) A lot of the problems are because of the way the payment reimbursement system is set-up for physicians. Maybe some of the things we should be talking about are the costs of training physicians and why medical school is so expensive. It comes down to changing the way folks are reimbursed.
    (a) This will be up for discussion in the payment delivery system reform.
14) The background should include a conversation on state's ability to handle the fiscal side of these recommendations.

V) Public Comment

A) George Swan, retired hospital administrator: In the first recommendation I drafted for the Commission about pivot tables that I have not seen during this discussion is the power of data transparency for local transformation. Bottom-up transformation is better than top-down transformation that dictates where people go. This is the biggest emphasis I recommend. In terms of workforce database, I sent a pivot table from CHI that gives an idea of how it could work with regards to transparency. I spoke with Steve Holloway after the last meeting and he provided a summary document of everything the Office of Primary Care is doing - it includes DORA licensing information, federal provider identification, APCD information, etc. It will be very rich in your data set.

B) Ryan Biehle, Colorado Academy of Family Physicians: Workforce has been a great topic and discussion. In general, we are supportive of where the recommendations have gone so far. GME is important to look at and a positive step. Another important aspect is the Colorado Health Service Corp, we know the cost of medical education is skyrocketing and is a huge deterrent for those that want to go into primary care but can't afford the upfront risk of being $200K in debt. To the extent we can reduce those risks up front, the better off we'll be. You can tie those things to commitment to primary care service after graduation and increase the numbers going into primary care and family medicine. We want focus to be on ensuring Colorado has a robust primary care workforce. How we define that is worth a discussion. One issue to bring up, another key consideration in the workforce discussion, is the notion of physician or health professional burnout. If we don't address long term issues of general provider burnout then we're not really helping ourselves that much. The literature on this topic is not that robust, but at least one study has shown that physician burnout costs Canada about $215 million, primarily in primary care.

1) Is there any specific recommendation this body could look at to help address burnout?
   (a) Tried to do some preliminary research, but didn't find much in a quick scan. Things to generally think about are around administrative costs and regulatory burdens – physicians spend a lot of time doing paper work which is not why many providers go into medicine. Another area is payment and delivery reform, if you can allow physicians to spend more time with patients and not charge a fee for service, you can probably move the needle on burnout problems.
2) Because of paperwork demands and low reimbursement, it is a deterrent to choose family medicine as a specialty. I'm more concerned with people being burned out opposed to early retirement.
   (a) I didn't find any data about early retirements, the study I did look at was in Canada and it demonstrated early retirements. I think this is one component of it, the other component is the quality of time in practice. If you're not happy with your job, the quality of your work decreases and that is another issue to be concerned about.

VI) CHI Memo on Spending by Income – Tamara Keeney

A) CHI looked at data on personal health care spending by income at the request of the Commission. The numbers provided are estimates since this data is not publically available.
B) Highest health care spending was for households under the $25K income category – we think this is likely due to elderly and retired individuals falling into this category. It is important to consider age when looking at income categories and health status may be an important driver in this.
   1) In terms of our report, it would be important to clarify that the data needs refinement.
C) Commission discussion:
   1) When you say "personal health care spending," is that what the individual pays or the total cost?
      (a) It is the total amount including out-of-pocket and any third party payer expenditures.
   2) What is the point of this data for the report? Because it is so dependent on health status, I'm not sure what I get out of this.
      (a) The request came from the research group; the request was originally for geography which wasn't available, so CHI looked at income and age instead.
   3) Relative to discussion around income, what I'm hearing is that although we can look at cost by income, it's hard to pinpoint the determinant because someone with a $25K income may be retired and in hospice, or could also be a young person just entering the workforce. It's hard to make any meaningful conclusions because there are too many variables.
D) Decision by the Commissioners to not use data from this memo in the November report.
   1) We can clarify this was an area we started to look at but there wasn't enough conclusive information to draw a conclusion. If this isn't an area of interest, then it might not be worth mentioning in the report.
   2) There is a substantial amount of data and literature to look at on this issue that is not reflected in this memo.
   3) Social determinants is a topic area the Commission will discuss and can take a more meaningful look at these issues to include in the next report.

VII) Stakeholder questionnaire responses – available at:
https://www.colorado.gov/pacific/cocostcommission/record-input-received

A) The Commission has begun receiving responses to their stakeholder questionnaires. The completed questionnaires are available on the Commission's website at the address above.
B) Commission discussion:
   1) Is there a way to correlate comments based on topic areas and common themes?

(a) Staff has talked about that and it would be helpful to create some sort of executive summary/matrix/one-pager. If we did this, what would Commissioners want to see in it?
(b) Commissioners should also try to pick up their own one-off insights from the questionnaires that we could further develop and look into for a recommendation.

2) Would like to express gratitude to all the groups that have put time into responding to the questionnaires.
3) It was nice that most responses were introspective.
4) There may be value to have some of the respondents come present to the Commission on some of their input, including:
   (a) CCHN primary care work.
   (b) Super utilizers
   (c) Direct primary care
   (d) Choosing wisely
5) How do we process all this input? There is a lot of good information and we want to be respectful of the perspectives provided to the Commission. Would like Commissioner ideas on how to use this input.
   (a) Organize by topic and create a panel presentation to provide perspective on those topics
      (i) In addition, should have like groups come in at the same time and discuss the topics. I think we'll have very different questions for different perspectives.
      (ii) Commissioners should let Keystone know any potential panelists they want to hear from sooner, rather than later, to help plan in advance.
   (b) Create spreadsheet organized by topic that shows different positions/perspectives and commonalities - ACTION
   (c) Have commissioners pull out any insights from the questionnaires that were surprising or created an "ah-ha!" moment – then perhaps bring those groups in to present.

VIII) Updates – Bill Lindsay/ Commissioners

A) November report timeline update:
   1) Keystone and CHI developed a draft timeline that has been presented to the Commissioners.
   2) We want to make Commissioners are aware of the timeline now because it will be a quick process and we will need their input during a short timeframe.
B) Julie Krow is the new delegate to the Commission from Colorado Department of Human Services, replacing Dee Martinez who recently retired. Julie will serve in an ex-officio basis.
C) The deadline for the Milliman Physical Therapy co-pay study is November 1st. They are currently drafting the report and will verify by Monday when a draft will be ready to review.
   1) We may want to schedule a meeting for the consultant to come meet with the Commission to answer any questions we might have.
D) Several members have let us know about their contacts with legislators – we appreciate that communication, and want to remind members to be careful and consistent with their messaging.
E) Meeting on October 12th is Columbus Day, the Commission will still meet on that day.

IX) Public Comment:

A) George Swan: Comments were right on with regard to CHI report; numbers matter. Sometimes it happens that numbers appear as truth, but the more you dig down it turns out that is not the case. With regards to MEPS data, I don't understand why Colorado doesn't have access to this information. Five percent of the population accounts for 50 percent of spending and 50 percent of population accounts for three percent of spending. People over 65 account for 33 percent of spending. I put a lot of time into putting forward a recommendation that was proposed at last

meeting about PERMA – is there anyone who has read the recommendation to do PERMA in Colorado? It is online and I urge you to read it and enjoy the hyperlink to the 30 minute YouTube video. You should also order the book and read it, I believe PERMA is a blockbuster recommendation to change the world. When you look at AHRQ, they say 21 percent of high spending health care costs are people with mental health issues, of which the majority is depression. The author is incredibly clear that money doesn't correlate to well-being. He is incredibly keen to show the evidence behind all his assertions. I read the book and want to leave you with a couple of his conclusions – depression medications are only palliative, PERMA is an antidote for depression. PERMA correlates to health status, a high PERMA score is imminently teachable and learnable. He has established a commitment to have 51 percent of population flourishing by 2051. You can take the recommendation I wrote and replace it with any state in the country and they can take it on just like Colorado. You need to read the book to understand how important the PERMA methodology is for the state of Colorado.

Adjourned at 3:10pm